



**Migraine Prophylaxis/Treatment and
Cluster Headache
Prior Authorization Form**

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| <p align="center">Fax completed form to: 855-207-0250</p> <p align="center">For questions regarding this prior authorization, call 866-773-0695</p> |
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| <p>Prior Authorization Vendor for ND Medicaid</p> |
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ND Medicaid requires that members receiving a prescription for migraine treatment/prophylaxis or cluster headache to meet specific clinical criteria for coverage which can be found at <https://ndmedicaid.acentra.com/ndpdl/>

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|--|----------------------|------------------------------------|----------|
| Member Name | Member Date of Birth | Member Medicaid ID Number | |
| Prescriber Name | Prescriber NPI | | |
| Telephone Number | Fax Number | Address | |
| Diagnosis for the Request: | City | State | Zip Code |
| Requested Drug, Strength, and Directions: | | Dosage Form (e.g., tablet): | |

Section A: Migraine

- How will the requested product be used?
 Treatment Prophylaxis
- For **prophylaxis** requests only:
 - Number of migraine days per month: _____
 - Current severity of migraine: _____
 - Current duration of migraine: _____

Section B: Cluster Headache

- Has the member had at least 5 attacks fulfilling the following:
 - Severe or very severe unilateral orbital, supraorbital YES NO and/or temporal pain lasting at least 15 minutes
 - Occurring with a frequency of \geq every other day YES NO
 - One of the following symptoms (check all that apply)
 - Sense of restlessness or agitation
 - Conjunctival injection and/or lacrimation ipsilateral to headache
 - Nasal congestion and/or rhinorrhea ipsilateral to headache
 - Eyelid edema ipsilateral to headache
 - Forehead and facial swelling ipsilateral to headache
 - Miosis and/or ptosis ipsilateral to headache

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|--|--------------------|------------------|
| List all failed medications and reason for failure: | Start Date: | End Date: |
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Clinical justification explaining why the member is unable to use the preferred agents (only applicable if criteria requires):

Renewal Requests only: assessment of the member's clinical benefit since starting the requested agent (migraine: e.g., change in migraine frequency, pain intensity, or duration from baseline by at least 50%)

I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.

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| Prescriber (or Staff) / Pharmacy Signature** | Date |
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****:** By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.